Parental Custody Negotiations and Health Insurance Access for Children

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Abstract

Family practitioners who provide divorce education programs should be aware that a child in a sole-custody household (especially one headed by the father) is highly likely to lack insurance coverage for access to health care services for healthy development. Examining 543 divorce records in New Hampshire, the author analyzed coverage across divergent family types following custody negotiations and found that a child in a sole-custody household was at higher risk for lacking coverage than was one in a shared-custody household. These results were confirmed by a chi-square test and logical regression statistical analysis. In a multivariate analysis, the author found that teenagers, children whose parents earned high incomes, and those with working mothers were likely to be covered, although the likelihood was lower in the case of daughters.

Introduction

THERE ARE MANY DECISIONS that divorcing parents are confronted with. One such decision is which parent will be responsible for providing health insurance for their children. This is a critical decision for parents because access to health insurance coverage is paramount to the healthy development of their children (Edmunds & Coye, 1998). The purpose of this study was to examine the at-risk status of children not having access to health insurance coverage across divergent family types formed as a result of parental custody negotiations at the time of divorce in New Hampshire. The objectives of this study were to ascertain (a) whether differences exist in children's family type and in their access to health insurance coverage and (b) whether family type has an effect on this coverage.

Rationale

As important as access to health insurance coverage is, government data show that a large number of children lacked such coverage throughout the 1990s. According to the U.S. Bureau of the Census (1995), in 1993, 13.7% of all children were uninsured. Despite all of the national attention that was devoted to children who lacked health insurance, by 1999 the percentage of children without health insurance coverage (13.9%) remained essentially the same as in 1993 (Mills, 2000).

Mills (2000) found that children living in single-parent households in 1999 were more likely not to be covered by health insurance than were children living in married-couple households (18% vs. 12%, respectively). The percentage of uninsured children in married-coupled households was slightly below the national rate of 13.9% in 1999 for all children. In contrast, the percentage of children who lacked access to health insurance coverage in single-parent households was above this rate. An increasing number of children in single-parent households is at risk of not having access to health insurance coverage. The U.S. Bureau of the Census (2000) reported that the number of married-couple households with children decreased from 76% of all households in 1990 to 72% in 1999. During this same time the number of children living in single-parent households increased from 24% to 28%. A sizable proportion of single-parent households can be attributed to divorce. The U.S.

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Bureau of the Census (2000) reported that in 1998 the divorce rate in the United States (4.3%) was essentially half that of the marriage rate (8.3%).

A critical aspect of the divorce process often involves parents negotiating such complex issues as which parent should provide care and sustenance for their children. In the past, researchers have examined outcomes of negotiation for parental custody and for awarding child support (Arditti, 1992; Teachman & Polonko, 1990). There is virtually nothing known, however, about children's health insurance coverage status as an outcome of divorce negotiations. Kronick and Gilmer (1999) examined the relationship between marital status and health insurance coverage. These researchers, however, focused exclusively on adults. Kronick and Gilmer found that married or widowed adults were more likely to be covered by health insurance than were divorced, separated, or never-married adults (58% versus 42%, respectively). As with Mills (2000), who compared the health insurance coverage rates of married-couple and single-parent households, information from Kronick and Gilmer concerning divorced households is meshed with other family types. This makes it difficult to glean from these studies the extent to which access to health insurance coverage is a specific problem for divorcing parents and their children.

In this study I expand on this prior body of knowledge on health insurance coverage (Kronick & Gilmer, 1999; Mills, 2000) by examining the at-risk status of children not having access to health insurance coverage across divergent family types formed as a result of parental custody negotiations at the time of divorce. Along with child support, health insurance is an expense that often has to be paid out of parents' limited resources. Donnelly and Finkelhor (1993) found that divorced parents who shared the living arrangement in caring for children had greater resources at their disposal than did divorced parents who lived with their children as a single parent. This difference in parents' resources can affect the health insurance coverage status of their children.

Analysis of children's family type and access to health insurance coverage could suggest the need for family practitioners to serve as health insurance advocates in their work with divorcing parents. Family practitioners providing crisis counseling during custody disputes (Berlin & Izen, 1991; Counts & Sacks, 1985) and divorce education programs that focus on both custody and health issues (Geasler & Blaisure, 1998) are in unique positions to serve as advocates for helping to ensure that children in all family types are covered by health insurance.

Literature on Children's Access to Health Insurance

In examining children's health insurance status, researchers have relied on data sources such as the U.S. Current Population Survey (Edmunds & Coye, 1998; Mills, 2000) and Medical Expenditure Panel Survey (Weinick, Weigers, & Cohen, 1998). As discussed above, children living in married-coupled households have greater access to health insurance coverage than do children in single-parent households (Mills, 2000). Weinick et al. (1998) found that the majority of uninsured children lived in working families. Children with two employed parents, however, were more likely to have access to health insurance coverage than were children with only one employed parent. Edmunds and Coye (1998) found that children with full-time employed parents who earned 0% to 133% of the poverty level lacked access to health insurance coverage. Apparently, parents with uninsured children in the household are working, but they are in low-paying jobs. Children with parents who have obtained more than 12 years of education have greater access to health insurance coverage than do children who have parents with a high school diploma or less (Edmunds & Coye, 1998; Weinick et al., 1998).

The U.S. Bureau of the Census (1999) and Edmunds and Coye (1998) found that children in the age range of 13 to 17 years had greater access to health insurance coverage than did children under 6 years old. White children were more likely to be covered by health insurance than their non-White counterparts (Mills, 2000). Because race is not recorded in divorce records, this variable will not be included in this study.

Method

Data Collection and Sample

Divorce data were obtained from superior courts in the New Hampshire counties of Strafford and Carroll. These counties were chosen primarily because of their geographical location in the state. Divorcing parents living in urban Strafford County have greater access to major industries and job opportunities than do their counterparts living in rural Carroll County (Slater & Hall, 1996). Moreover, Strafford County is a much wealthier county than Carroll County. A computerized listing of all the marital records involving minor children between September 1, 1995, and January 21, 1997, was obtained from the clerks in these two courts. This list included 543 finalized divorce records, which contained demographics on both parents and children.

The uniform support order was also a part of these records, and it contained information on child support and children's access to health insurance coverage. Information concerning specific types of health insurance plans was not included in the uniform support order. Thus, my intent in this study was not to examine specific types of health insurance coverage plans that children may have had access to, but rather to ascertain whether they had access to any health insurance coverage at all at the time of their parents' divorce.

Data Analysis

A chi-square test was used to ascertain whether differences existed in children's family type and access to health insurance coverage. A logistic regression procedure was used to ascertain whether family type had an effect on this coverage. Other demographics of both parents and children were used as controls. As reported in Tables 1 and 2, variables in the model were coded as *scaled* (parental income and parental education), *continuous* (number of sons and daughters and the total number of children), and *categorical* (parental employment status, children's age, children's family type, access to health insurance, and child support award status).

Both the chi-square test and the logistic regression model are appropriate for analyzing categorical dependent variables (Norusis, 1999), such as children having access to health insurance coverage. Missing data were not included in either analysis. The cutoff point for statistical significance was set at the .05 level in both the chi-square test and the logistic regression procedure.

Results

Demographics of the Sample. A demographic profile of the sample is provided in Table 1. Fathers were more than twice as likely as mothers to have a mean monthly gross income

Table 1. *Demographics of Sample and Measurement of Variables*

Variables	Number	%	Measurement
Mother's monthly earnings			Scale
1 = <$2,000	413	82	
2 = $2,000–$2,999	71	13	
3 = >$3,000	29	5	
Father's monthly earnings			Scale
1 = <$2,000	305	56	
2 = $2,000–$2,999	141	26	
3 = >$3,000	97	18	
Mother employed			
Yes	422	79	Categorical
Father employed			
Yes	470	92	Categorical
Mother's education			Scale
1 = 0–8	7	1	
2 = 9–12	308	57	
3 = 13–16	202	37	
4 = >17	24	5	
Father's education			Scale
1 = 0–8	10	2	
2 = 9–12	324	60	
3 = 13–16	177	33	
4 = >17	27	5	
Children aged 13–18			Categorical
Yes	96	18	
Children aged 6–12			Categorical
Yes	260	48	
Children aged 0–5			Categorical
Yes	186	34	
	Mean		**Measurement**
Number of daughters	1.31		Continuous
Number of sons	1.31		Continuous
Total number of children	1.78		Continuous

Table 2. *Children's Family Type, Health Insurance Coverage, Child Support Award Status, and Measurement of Variables*

Variables	Number	%	Measurement
Family Type			
Shared			Categorical
Yes	74	14	
Mother-only			Categorical
Yes	400	74	
Father-only			Categorical
Yes	76	14	
Health insurance coverage			Categorical
Yes	412	80	
Child support award			Categorical
Yes	473	87	

greater than $2,000 (44% vs. 18%, respectively). Fathers (92%) were more likely to be employed than mothers were (62%). Both fathers (60%) and mothers (57%) were likely to be in the group having 9 to 12 years of education. Parents were likely to have one son and one daughter. Children were mostly in the middle (6 to 12 years) age range (48%).

Family Type, Health Insurance, and Child Support. As reported in Table 2, close to three fourths (74%) of the children were living in mother-only households. Eighty percent of the children had health insurance coverage. The majority (87%) of the children were awarded child support.

Chi-Square Test. Results from the chi-square test are reported in Table 3. Children's access to health insurance coverage was found to differ by family type. Children living in shared-custody households (89%) were more likely to be covered by health insurance than were children living in sole-custody households with their mothers (80%) and fathers (72%). Although a fifth of the children living in mother-only households were uninsured, well over a quarter (28%) of children in father-only households were without health insurance coverage.

Logistic Regression. As reported in Table 4, shared custody (2.453) increased the log odds of children having access to health insurance coverage. Regarding controls, both fathers' (1.77) and mothers' (1.66) earnings increased the log odds of children being insured. Mothers' employment (1.11) also increased the log odds of children being covered by health insurance. Being a teenager (1.31) increased the log odds of children being insured. As the number of daughters (-.81) increased in the household, the log odds of these children having access to health insurance coverage decreased.

Discussion

Chi-Square Test

Children living in shared-custody households were found to be less at risk of not being covered by health insurance than children living in sole-custody households. Both fathers ($2,516) and mothers ($1,514) in the shared-custody households had higher mean monthly gross earnings than did fathers ($2,064) and mothers ($1,493) in the sole-custody households, though the difference in the mother's earnings is negligible ($21 per month). Parents in shared-custody households had more resources at their disposal that could be used to obtain health insurance coverage for their children. It should be noted that the 11% of children in shared-custody households who were without health insurance coverage was slightly below the 12% national uninsured rate reported by Mills (2000) for children in married-couple households.

The percentage of children who lacked access to health insurance coverage in mother-only households in this study (20%) is in range with Mills' (2000) 18% national uninsured rate for children living in all single-parent household types. In comparison, the percentage of children who were not covered by health insurance in father-only households in this study (28%) is relatively high. Thus, findings in this study suggest that when one examines the seriousness of the problem of uninsured children, it is important to separate the various single-parent household types, not lump them together.

This difference in the health insurance coverage status of children can highlight the need for specific interventions. It is interesting that, although mother-only households had a much lower mean monthly gross income ($1,493) than father-only households did ($2,064), children in the mother-only households were less at risk of not having access to health insurance coverage than were children living in the father-only households. Thus, children in father-only households are in greater jeopardy of not having access

Table 3. *Children's Access to Health Insurance Coverage by Family Type*

Family Type	% No Access (*n*)	% With Access (*n*)
Shared	11 (8)	89 (65)
Mother-Only	20 (75)	80 (299)
Father-Only	28 (17)	72 (43)

$\chi^2 = 6.376$. $p = .04$.

to needed health care services. Lack of these services could affect children's psychological, emotional, and physical development (Families USA Foundation, 1997).

Logistic Regression

Children in shared-custody households were likely to have access to health insurance coverage. This multivariate finding confirms the above bivariate analysis. With respect to controls, children who had both mothers and fathers with higher earnings were likely to be covered by health insurance. Higher income parents have the ability to obtain health insurance coverage for their children. This finding is similar to Edmunds and Coye's (1998) research finding on parents' earnings and the health insurance status of their children. Teenage children were likely to be covered by health insurance. As the data in Table 5 show, these children's parents had mean monthly gross earnings that were higher than their younger counterparts' parents. There is a positive relationship between parents having higher earnings and their children being covered by health insurance. This finding is in accordance with data from the U.S. Bureau of the Census (1999) and with Edmunds and Coye's research findings on children's age and health insurance status.

Children with employed mothers were likely to have access to health insurance coverage. When mothers were employed and providing health insurance, fathers had an unemployment rate of 13%. It is plausible that these mothers were filling in the gap for fathers when the fathers were unable to obtain health insurance coverage for their children.

As the number of daughters increased in the household, the likelihood of these children being insured decreased. An explanation for this unexpected finding is that parents with at least two uninsured daughters had a mean monthly gross income that was $1,093 less than their counterparts who had at least two daughters with health insurance ($1,252 vs. $2,345). Health insurance might have been too expensive for the first group of parents.

Conclusion

Children in shared-custody households were found to be less at risk of not being covered by health insurance than were their counterparts living in sole-custody households.

Table 4. *Logistic Regression of Children's Family Type as a Predictor of Access to Health Insurance Coverage (N = 468)*

Variables	Coefficients
Family type	
Shared	2.45*
Mother-only	2.12
Father-only	1.27
Controls	
Father's earnings	1.77**
Mother's earnings	1.68**
Father employed	0.49
Mother employed	1.11**
Father's education	0.41
Mother's education	-0.29
Child age (13–18)	1.31*
Child age (6–12)	0.18
Number of daughters	-0.81*
Number of sons	-0.70
Total number of children	0.52
Child support	-0.04

Model $\chi^2 = 124.53$, $p = .001$.
*$p = .05$. **$p = .001$.

Table 5. *Parents' Earnings by Age of Children*

	Earnings	
Children's Age	Mother	Father
0–5	$1,325	$1,878
6–12	$1,452	$2,334
13–18	$1,644	$2,393

My conclusion is that children living in sole-custody households, particularly those headed by fathers, have a high chance of experiencing a gap in health insurance coverage, which implies reduced access to health care services needed for healthy development.

Implications for Family Practitioners

Children living in sole-custody households who were not covered by health insurance were found to have parents with low earnings. Family practitioners providing counseling services and divorce education programs can play a pivotal role in informing these parents not only about the need to make sure that their children are covered by health insurance, but also about health insurance programs that can assist them in obtaining coverage for their children.

The federally funded Medicaid program and the new State Children's Health Insurance Program (S-CHIP) are two health insurance options that specifically cater to low-income children. S-CHIP gave the states additional funds and more flexibility to both find and enroll hard-to-reach uninsured children. Among other major provisions, S-CHIP creates financial incentives aimed at encouraging states to go beyond the eligibility limits previously established by Medicaid in order to bring health insurance coverage to children through 200% of the federal poverty line (Perloff, 1999).

As critical as the Medicaid program is, Selden, Banthin, and Cohen (1998) reported that 4.7 million children aged 18 years old or younger were uninsured, despite being eligible for Medicaid. This represents approximately 2 of every 5 uninsured children in the United States. The Medicaid program is a heavily underutilized health insurance option.

In many states, parents seeking a divorce are required to complete a divorce education program before they are awarded a divorce. These programs are often designed to address both custody and health issues, as well as others, that arise from divorce (Geasler & Blaisure, 1998). Thus, in addition to private counseling, divorce education programs can also serve as a forum where parents can be informed of the Medicaid program and S-CHIP.

Family practitioners delivering divorce education programs serve a large captive audience. For example, one educational program for divorcing parents, Children Cope With Divorce, offers about 280 seminars nationally, involving an average of 9,886 divorcing parents per month, or 118,632 parents per year (Fisher, 1997). The dissemination of information about the underutilized Medicaid program and S-CHIP through divorce education programs can be an effective way to both reach and enroll many parents in these health insurance programs. The stigma associated with these programs is a barrier that family practitioners need to address when encouraging parents to utilize public health and welfare programs such as Medicaid and S-CHIP (Groskind, 1994). Adults are often wary of the stigma that is attached to being a beneficiary of public health and welfare benefits. Family practitioners can help remove this stigma by continuing the fight for universal health care, at least for children. The absence of universal access to health care is the main problem for many in the U.S. health care system (Scuka, 1994).

Limitations

New Hampshire, like many states, has its own particular (somewhat conservative) political context and economy, making it difficult to generalize about findings in this study. These findings do, however, inform us that the serious issue of children's access to health insurance coverage needs to be an integral part of custody negotiations where parents are likely to be awarded sole physical custodial rights.

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